REPORT RESUMES

ED 016 505 LI 000 094

PROCEEDINGS OF 1967 ANNUAL MEETING OF THE WASHINGTON, D.C., REGIONIAL GROUP, MEDICAL LIBRARY ASSOCIATION (WASHINGTON, D.C., VETERANS ADMINISTRATION HOSPITAL, OCTOBER 27, 1967).

BY- TEDESCO, CLAIRE R.

MEDICAL LIBRARY ASSN., WASHINGTON, D.C. REG. GROUP

PUB DATE 67

EDRS PRICE MF-$0.50 HC-$2.96 72P.

DESCRIPTORS- *LIBRARY ASSOCIATIONS, *LIBRARY COOPERATION, *MEDICAL LIBRARIES, INTERLIBRARY LOANS, LIBRARY PROGRAMS, LIBRARY SERVICES, MEDICAL SERVICES, *REGIONAL PROGRAMS, AUTOMATION, NETWORKS, INFORMATION SYSTEMS, MEDICAL LIBRARY ASSOCIATION, VETERANS ADMINISTRATION, REGIONAL MEDICAL PROGRAM, WASHINGTON D.C., PILOT AUTOMATED HOSPITAL INFORMATION SYSTEM STUDY (PILOT AHIS),

THESE PROCEEDINGS CONSIST OF PAPERS PRESENTED AT THE MEETING, GROUPED INTO TWO SUBJECT AREAS--THE VETERANS ADMINISTRATION LIBRARY PROGRAM AND THE REGIONAL MEDICAL PROGRAM OF THE NATIONAL INSTITUTES OF HEALTH. THE IDEA OF THE SUCCESSFUL MEDICAL LIBRARY AS A PHYSICIAN'S LABORATORY IS EXPLORED, REFERRING TO VA HOSPITAL LIBRARIES. A DESCRIPTION OF THE PILOT AUTOMATED HOSPITAL INFORMATION SYSTEM STUDY (PILOT AHIS) IS REVIEWED, WHILE THE FORCES INFLUENCING VA LIBRARY SERVICES ARE OUTLINED IN AN ABSTRACT OF A LONGER PAPER. THE ROLE OF THE VA CENTRAL OFFICE LIBRARY IN THE VA LIBRARY NETWORK AND A DESCRIPTION OF LIBRARY SERVICE IN THE WASHINGTON VA HOSPITAL ARE THE OTHER TOPICS COVERED. THE SECOND GROUP OF PAPERS OPENS WITH THE SUMMARY OF A REVIEW OF CURRENT MEDICAL LIBRARY ASSOCIATION PROGRAMS, FOLLOWED BY AN OVERVIEW OF THE REGIONAL MEDICAL PROGRAM AND ITS RELATION TO MEDICAL LIBRARY ACTIVITIES AND A DISCUSSION OF THE ROLE OF THE MEDICAL LIBRARY ASSOCIATION IN REGIONAL MEDICAL PLANNING. THE COMPLETE TEXT OF THE PAPER ON VA LIBRARY SERVICES IS PUBLISHED IN THE JANUARY, 1968, "BULLETIN OF THE MEDICAL LIBRARY ASSOCIATION" AS "THE VETERANS ADMINISTRATION LIBRARY PROGRAM," BY HENRY J. GARTLAND. (JB)

LI 000 094

ED016505

PROCEEDINGS OF 1967 ANNUAL MEETING

Washington, D.C. Regional Group
Medical Library Association

VETERANS ADMINISTRATION HOSPITAL
WASHINGTON, D.C.
OCTOBER 27, 1967

LI 000 094

PROCEEDINGS

of

1967 ANNUAL MEETING

Washington, D.C. Regional Group

Medical Library Association

VETERANS ADMINISTRATION HOSPITAL
WASHINGTON, D.C.
October 27, 1967

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL OFFICE OF EDUCATION POSITION OR POLICY.

PREFACE

The Committee of the 1967 Annual Meeting of the Washington, D.C. Regional Group of Medical Librarians is pleased to make available the papers presented at the meeting.

These papers are grouped into two broad subject areas and include information perhaps presented for the first time to any group of librarians. One deals with the Veterans Administration, its library program, and a brief glimpse into the automation of hospital information; the other is concerned with the Regional Medical Program of the National Institutes of Health, the support it can offer to medical libraries, and the relationship between Medical Library Association and RMP.

Each program participant presented a paper with information of value to many medical librarians. We feel that these papers should be disseminated to a larger audience than that privileged to attend the meeting; hence, this publication.

MRS. CLAIRE R. TEDESCO
Chairman

COMMITTEE

Miss Inez Callaway, Washington VA Hospital
Mr. Sal Costabile, National Library of Medicine
Mr. Jess Martin, National Institutes of Health
Miss Joyce Smith, Howard University

CONTENTS

Greetings from MLA President
Mr. Scott Adams

The Medical Library: Another Laboratory
Dr. Milton Ginsberg

Automated Hospital Information System: A Review
Dr. L. G. Christianson

VA Library Service: A Peek into the Future
Mr. Henry J. Gartland

The Role of VA Central Office Library
Mrs. Claire R. Tedesco

Library Service in a VA Hospital
Miss Inez Callaway

Medical Library Association Programs
Mrs. Helen Brown Schmidt

Comments on the Regional Medical Programs
Mr. Alphonse Strachocki

Medical Library in the Regional Medical Program
Mrs. Jacqueline Felter

VETERANS ADMINISTRATION
Library Service
-DIMENSIONAL
PROGRAM

Mr. Henry J. Gartland, Director of Veterans Administration Library Service, joins the Committee of the 1967 Annual Meeting of Washington, D.C. Regional Group of Medical Librarians to pose for a pre-meeting picture. From left to right are Mrs. Claire R. Tedesco, Chairman, VA Central Office; Mr. Jess Martin, National Institutes of Health; Miss Joyce Smith, Howard University; Miss Inez Callaway, Washington VA Hospital; Mr. Gartland; and Mr. Sal Costabile, National Library of Medicine.

Program participants pictured are: (from left) Dr. L.C. Christianson, VA Director of Automated Hospital Information System; Al Strachocki, Regional Medical Program, National Institutes of Health; Mrs. Jacqueline Felter, President-elect, Medical Library Association; Dr. Milton Ginsberg, Chief of Staff Trainee, Washington VA Hospital; Mr. Henry J. Gartland, Director VA Library Service; Mrs. H.B. Schmidt, Executive Secretary, Medical Library Association; Mrs. C.R. Tedesco, Chief, VA Central Office Library; Miss Inez Callaway, Chief Librarian, Washington VA Hospital.

GREETINGS FROM MLA PRESIDENT

From

Mr. Scott Adams
Deputy Director
National Library of Medicine
Bethesda, Maryland
President, MLA

The following message from Mr. Adams was read by Mrs. Jacqueline Felter, President-Elect, MLA.

"I regret very much that a conflict in appointments keeps me from meeting with my own regional group this fall. The Medical Library Association Board of Directors is, however, ably represented by Mrs. Jacqueline Felter, Vice-President and President-Elect, and I am sure that if your meeting should result in actions or resolutions which you would like to bring to the attention of MLA that Mrs. Felter will be glad to act as your agent.

I do not need to wish you a successful meeting; the Washington, D.C. Regional Group always has one. Claire Tedesco has arranged a most interesting program. It is fitting that your hosts for the occasion are from the Veterans Administration. Through the years the VA medical library system has been one of the major sources of strength and support for the development of medical librarianship in the country. MLA owes Henry Gartland and his predecessors a vote of thanks for the many battles they have fought in the upgrading of the profession.

If there is one principal message that I would like to bring to you, it is that we must now turn our attention to developing the potential of the hospital library as a focus for the new programs of continuing education in the health sciences. This was the theme, some of you may remember, at the Miami meeting; we are again going to accent it in Denver. In this we can make common cause with medical educators, with the administrators of the Regional Medical Programs, and with the educators in the VA. The hospital libraries have a long way to go before they can become educational centers, and we must help them.

Plans for the Denver meeting are well under way. Brad Rogers promises us a great program, and the setting for the meeting is superb. Ron Watterson will shortly be sending out preliminary announcements for a week long pre-Conference institute of continuing education courses.

I hope to see most - if not all - of you in Denver."

THE MEDICAL LIBRARY: ANOTHER LABORATORY

By

Dr, Milton Ginsberg
Chief of Staff Trainee
VA Hospital
Washington, D.C.

It would be appropriate prior to speaking about the Medical Library as a laboratory, to pay tribute to those who probably made all this possible. "Blessings upon Cadmus, the Phoenicians, or whoever, it was that invented books." This deserving statement was written by Thomas Carlyle in a letter to R. Mitchell. And I wish to offer similar salutations and welcome all of you on behalf of the professional staff at this hospital. I, personally, feel myself a part of you, not because I had the opportunity of lending a hand in the affairs of a medical library, but perhaps more so because of my undying love for books of all kinds. (This statement can be well substantiated by my dear friends and co-workers, Miss Anne Connor and Mrs. Helen Goodell, VA Librarians, who I am delighted to see among us here today.) I envy all of you. To grow up in an atmosphere of books, is indeed, a rare privilege. It's a grand opportunity for which you should be grateful. Books, like friends, are constant and never fail us. As we grow older, our libraries become a greater source of comfort to us. One turns to his books to learn of the past, to get ideas or opinions of the present, and to look for signs of what the future may bring.

Physicians from early times were considered among the learned classes of society. One of their characteristics was the collection of private libraries either as a hobby, as a showpiece in the office, or actually for use in their work. From early times, it became evident that the private library was inadequate. The vastness of the medical fields made it necessary to either pool the private collections or maintain a centralized area where all important books and other writings could be located and consulted and cared for by persons particularly interested in them. Thus, the medical library was born, and your position established.

In the words of Harvey Cushing, a "library becomes a laboratory for the crystallization of ideas, perhaps long expressed, out of which process new ideas have their birth." Like the laboratory, the medical library is the workshop for the literary physician. It is just as important as the laboratory is to the bacteriologist, hematologist or pathologist. Most of us in medicine are craftsmen, and the books, in a great measure, are our tools. It is, therefore, important for us to have

friends, are constant and never fail us. As we grow older, our libraries become a greater source of comfort to us. One turns to his books to learn of the past, to get ideas or opinions of the present, and to look for signs of what the future may bring.

Physicians from early times were considered among the learned classes of society. One of their characteristics was the collection of private libraries either as a hobby, as a showpiece in the office, or actually for use in their work. From early times, it became evident that the private library was inadequate. The vastness of the medical fields made it necessary to either pool the private collections or maintain a centralized area where all important books and other writings could be located and consulted and cared for by persons particularly interested in them. Thus, the medical library was born, and your position established.

In the words of Harvey Cushing, a "library becomes a laboratory for the crystallization of ideas, perhaps long expressed, out of which process new ideas have their birth." Like the laboratory, the medical library is the workshop for the literary physician. It is just as important as the laboratory is to the bacteriologist, hematologist or pathologist. Most of us in medicine are craftsmen, and the books, in a great measure, are our tools. It is, therefore, important for us to have

adequate tools, improving them as the frontier of knowledge advances. Much of our knowledge today is the result of the increased precision of our tools. It is distressing to see how frequently a doctor ceases his medical education after he is graduated. Fortunately, this is becoming less as post-graduate instruction and the desire for research is increased. One can readily distinguish between the doctor who is constantly in touch with the current medical literature, as contrasted with the doctor who has little or no interest in medical writings.

The medical library finds its prime place in graduate medical education, particularly in any approved residency program in any specialty. Effective training in modern medicine and its ramifications requires diligent self-learning, which can best be obtained by reading and working in the medical library. For this, he must consult the recent editions of so called reference books or standard texts - or newer texts that become useful and supplant others. For recent advances, a good set of current periodicals is imperative. At the same time, we must caution our residents on periodical printed matter. This I can best express by repeating the words of one of my professors in medical school. "Much of what is in a journal is crude and unsound. Only too often many of us remain under the influence of the last article we have read, as a woman under the sway of the latest fashion. There is a difference between seasoned and unseasoned knowledge." It is well for the resident that both kinds are available to him.

Besides routine training of the resident, the medical library must provide means for a further important program which has become so prominent in many of our hospitals, namely research. One need only glance at the list of eighteen approved and active residency specialties offered at this hospital alone, or review the 34 Medical Research Programs, including hundreds of individual research projects, to appreciate immediately, the importance of the medical library and particularly the library staff who must cope with the requirements necessary for the successful fulfilment of these programs.

Fully cognizant of the needs for residency training or research, the library staff must provide the necessary books and periodicals. Since our VA hospital libraries are often too small, and in some cases, lack necessary funds, they can hardly provide the same coverage within themselves as the Library of Congress or the National Library of Medicine. The staff must select, carefully, a representative number of textbooks, monographs and journals. An adequate library for study or research purposes has about 3/4 of the bound material consisting of back volumes of journals and approximately 1/4 of the collection in monographs and textbooks on all phases of medicine including basic sciences and other peripheral subjects. By peripheral subjects I mean the various other training programs included in the hospital, such as: Hospital Administration, Social Work, Dentistry, Nursing, Audiology, Psychology, Librarianship, Biometrics, to mention a few. To provide for this essential deposit of medical and para-medical knowledge, the librarian must expertly peruse the publishers' lists for new editions, new texts and monographs, discuss the needs with various members of the staff, and with the aid of the Library Advisory Committee, review each request for a text or journal, and purchase the selected ones all within the confines of allowable funds.

I stated that the libraries of the VA are not as elaborate as the big ones in regard to the number of books and periodicals stocked on their shelves. This fact is not entirely a true one. With the aid of our resourceful librarians, an extensive inter-library loan service has been developed. This use of such outside sources as nearby medical school libraries, the Library of Congress, and the National Library of Medicine, and many others has made the service to our own patrons equivalent to these mammoth collections.

Cataloging in the library has become, indeed, a science understood so well by you, the professional librarians. With your help the tedious and arduous task of installing the new system of cataloging in the VA will soon be completed. With this and other innovations, the stacks of books will no longer be a mysterious labyrinth to anyone seeking knowledge in medicine or the para-medical fields.

While all of this help does not imply a short-cut to learning for a student or resident, since this is his own responsibility, it does offer a short-cut to information that will make learning more accessible. I was pleased to learn, that many colleges include a short course in the use of library references, catalogues, and indexes, as a part of their requirement in college English. This will definitely stand the students in good stead later. I am, however, chagrined at the great number of good medical students, residents, and excellent scientific researchers who are still unable to follow a proper course of reference work in the library. They have become dependent on the librarians to perform this task for them. This taxes the work of the already overburdened librarians. Perhaps, as a part of their orientation a brief elective course in the manner of searching the literature should be offered as a part of the medical training. Then again, since the tremendous volumes of scientific writing have outstripped the ability of many indexes to keep up the necessary pace to remain good reference tools, the new system MEDLARS may be the answer.

It would be feasible at this time to mention other difficulties encountered by the users of the medical library, particularly students and residents. Many of them fail to interpret the medical literature properly. The student of medicine may not understand the written communication of ideas. Some medical authors lack the ability to write clearly and a careless reader will jump to faulty conclusions. Others, like Osler, possess the gift of medical writing which has been manifested in many texts and periodicals. In addition, many good articles written in modern foreign languages have not been made available for reference due to the inability of our readers to translate them. A system for translation of this material when needed would indeed be a great boon for the VA Medical Library system. Though it behooves the teachers and supervisors to guide them in this respect, you librarians, with your subtle and understanding mannerisms, can put in some good words of advice. By stimulating the student of medicine or medical research to make frequent and proper use of the library, the prime goal of better serving our patients as well as his self education would be accomplished.

A proverb from the Old Testament can be restated here and perhaps should be hung outside the library door: "Receive my instruction, and not silver; and knowledge rather than choice gold. For wisdom is better than rubies; and all the things that may be desired are not to be compared to it." (Old Testament, Proverbs 8: 10, 11.)

In addition to all the qualities of a good medical library, perhaps its greatest asset is the help which you, the medical librarians offer. Without you, there would be no organization or system in the library. Your professional "KNOW HOW" in finding answers to the numerous questions, your ability to obtain literature from all sources, your patience in teaching the use of the catalogues and indexes, surely form the greatest facet in the use of the library for the training of residents and for the achievements by our research investigators. The Veterans Administration has become aware of your support function to patient care and medical education. You have attained, and deserve, your position in the important hospital triad: Patient Care, Research and Education, and the Medical Library. This awareness is borne out by the recently established special VA Programs, namely the "Librarian Work-Study Program" and the "Library Affiliate Trainee Program", which have been accomplished

in cooperation with accredited colleges and universities offering graduate degrees or undergraduate majors in library service.

Let me reiterate that the medical library is the physicians' laboratory, the books and periodicals his tools and equipment and, you, the medical librarian, God Bless You, his chief technician.

AUTOMATED HOSPITAL INFORMATION SYSTEM: A REVIEW

L. G. Christianson, M.D.
Project Director, AHIS
Veterans Administration
Washington, D.C.

An Automated Hospital Information System (AHIS) is a method of providing necessary, timely, integrated data to personnel within hospitals to improve utilization of existing patient care services and facilities. It is based on use of automated data processing (ADP) and electronic communication techniques. A coordinated multipurpose automated data system for a hospital must incorporate all patient data, wherever and whenever generated, necessary for operation of the hospital. The automated system will collect, record, store, retrieve, summarize, transmit and display this information primarily to assist the patient care team.

After several years of system analysis of the existing hospital manual data processing procedures and research in patient data automation, VA launched the Pilot Automated Hospital Information System Study ("Pilot AHIS") in the fall of 1964. The goal of this study is to design, develop, test, install and operate an experimental hospital information system based on automatic data processing in the

VA Hospital, Washington, D.C.

The study plan calls for early operation of a limited but representative initial system dealing with Admissions and radiology data. This will provide meaningful experience for the hospital by demonstration of potential benefits and problems. Simultaneously, project personnel will complete the design of the broader hospital-wide system outlined in this brochure. When a sufficiently detailed design for an integrated system has been established, costs and benefits will be studied to furnish a foundation on which a determination of feasibility of such a system for the VA Hospital, Washington, D.C., can be based.

The AHIS Team is also responsible for a follow-on project named "VA AHIS." This study will examine the feasibility of a VA-wide automated medical information system to serve all VA field stations such as general hospitals, psychiatric hospitals, outpatient clinics and domiciliaries. The VA AHIS study will derive data, design and experience from Pilot AHIS and from additional analyses. Conceptually, the VA-wide AHIS is visualized as a regional system in which one computer center in each region will serve a number of hospitals and clinics via a remote processing network.

AHIS design activity has proceeded under the following general concepts and constraints:

1. The system is primarily oriented to process information concerned with direct patient care.

2. The ultimate design objective of the system is to meet all feasible user information requirements and to interact directly with the user on an immediate response basis.

3. The system is designed to serve hospital personnel around the clock, seven days a week and to provide information where and when required with high reliability and convenience.

4. The first AHIS, while designed in the philosophy of "total systems," will constitute a basic or core system, subject to future refinement and expansion.

All of the wards and most of the service areas of the hospital will have conveniently located input/output terminals to provide two-way communication with the system. This will allow rapid entry, verification and receipt of data by hospital personnel. The system will produce many printouts specifically tailored to the information needs of hospital personnel. Because the computer has its own internal clock and calendar, many of these reports and messages will be automatically printed on a regular schedule. Other outputs will be available on demand.

Pilot AHIS has been divided into several logical parts identified as subsystems:

- Admissions and Dispositions (A&D)
- Medication
- Laboratory
- Radiology
- Ward Care
- Dietetic
- Surgery
- Central Service
- Clinic
- Patient Information
- Medical Administration

An example of a major AHIS subunit is the Medication System. This system consists of a number of processes and files linking the data functions of those organizational entities of the hospital involved in the ordering, preparation, distribution, administration and recording of medications. The medication order process begins when the physician writes a medication order or a prescription. When the order is entered into AHIS via the terminal, the computer checks the number of dosage units requested to see that the ordered dose does not exceed the maximum permissible dosage range stored in the computer formulary file. The patient's computer stored master record is checked to determine if a drug sensitivity caution has been recorded and the formulary file is also checked to see if the drug ordered is one of a group of drugs identified in the formulary as a potential sensitizer. If a drug sensitivity match occurs, the dosage ordered exceeds the formulary maximum, or the route of administration is incorrect, the order will not be accepted. Provision is made for the physician to override edits if in his opinion this is medically indicated. The system will automatically generate a pharmacy order if the drug is not in ward stock or if the stock level drops to a predetermined reorder point. The system will also handle all special prescriptions for individual patients. To assist nurses in administration of medications, the system will periodically scan the patient records and produce timely schedules and lists for assembling the medications and administering them to the patient. After verification by the nurse that she has given the items on her schedule, the system files are updated and ward stock inventories are automatically adjusted.

The system will monitor the number of doses of each medication administered each day and summarize this information for the physician. AHIS will also remind him when the order for a drug is to be reviewed and renewed. The automated system will include a "Formulary File" which will contain all drugs approved for general use by the hospital Therapeutics Agents Committee. Data items will include an identification number, the drug name, dosage form, unit size and maximum individual dose. Printouts of this file will serve as the "working formulary" for the wards and clinics of the hospital, with provisions for frequent update and revision.

These processes have all been programed and tested in the computer room. Medication activity over a several day period, using "live" data obtained from the hospital, has been intensively simulated.

The Radiology Subsystem is principally concerned with the ordering, scheduling and control of requests for diagnostic X-rays. The system is activated by entry of a doctor's order for a radiographic examination. Depending on the type of procedure (STAT, portable, routine, routine with necessary preparation on ward), appropriate schedules are set up and notices generated for preparation, meal holds and other related activities. A feature of this subsystem is a provision for automatic scheduling of routine procedures and for frequent readjustment of scheduling to promote efficient utilization of manpower and equipment. Should Radiology find itself ahead of or behind schedule, patient appointments can be rescheduled for earlier or later and the computer will dispatch the necessary messages required to place the adjusted schedule into effect.

In reporting the results of the reading of radiographs, an entry into the system notifies the ward that the exam is completed and a written report will follow. The reporting process also includes the ability to enter STAT impressions such as "film negative for evidence of fracture." The system will maintain an automated file of available diagnostic radiographic procedures. Printout of the file will be available at wards and service areas as an up-to-date diagnostic radiology catalog. These diagnostic radiology programs have been completed and extensively tested in computer room simulation. Diagnostic radiology has been selected, along with A&D, for installation and operation in the initial demonstration system.

The computing equipment available on-site for AHIS pilot experimentation is the IBM System/360, Model 40. The central processing unit has a core storage capacity of 131,000 8-bit bytes. Random access data storage is provided by disk storage drives. Each replaceable disk pack can store 7.25 million bytes of data. Magnetic tape drives provide additional bulk data storage. The computer is equipped with an internal programable timer or "clock" so that time-initiated processing is possible.

The computer system has been designed as a rapid-response system serving multiple remote input/output terminals "on-line."

This means that for practical purposes each terminal can gain immediate access to the central computer to input data or to receive a message. Through its communications controller, the Pilot AHIS computer can currently serve a maximum of 31 half-duples lines handling 40 remote terminals. The general purpose remote communication devices selected for initial operations are the IBM 1092 programed keyboard (a 10x16 matrix pushbutton device) compled to a 1052 keyboard printer, similar to a standard typewriter. The 1092 keys are overlaid with removable plastic templates or "keymats," on which are printed many types of data items such as medications, laboratory tests and results, radiology procedures and other preformatted items which correspond to computer-stored data tables and programs. Other peripheral equipment in the machine room includes a high-speed printer and a card read/punch device.

As part of its mission, the project has investigated and experimented with a variety of remote data input/output techniques and terminals. Knowledge gained in terminal research will be used to specify the remote terminal devices for an "ultimate" VA-wide system if an when such a system is determined to be feasible.

VA LIBRARY SERVICE: A PEEK INTO THE FUTURE

By

Mr. Henry J. Gartland
Director, Library Service
Veterans Administration
Washington, D.C.

ABSTRACT

The Veterans Administration Library Service is continuously responsive to the information requirements of the agency's policies which provide for the improved care and treatment of veterans through research, education, and clinical programs. At the same time, it participates in the planning of the Federal Government as a whole in providing library support for health care for the American people. There are both internal and external forces influencing VA hospitals and their libraries. Retirements and consequent recruitment of new people will necessitate a rethinking of the VA library program at the same time as external forces will be affecting the program. These external forces include the application of machines to library services through the development of in-house capabilities coupled with joint-use participation and P.L. 89-785 which provides for the exchange of medical information, sharing of facilities, and cooperative training programs.

The full context of Mr. Gartland's talk will appear in Bulletin of the Medical Library Association, January 1968, with the title "The Veterans Administration Library Program."

THE ROLE OF VA CENTRAL OFFICE LIBRARY

By

Mrs. Claire R. Tedesco
Chief Librarian
Veterans Administration
Central Office
Washington, D.C.

The Central Office Library of the Veterans Administration plays a 3-part role in the VA library network. Its primary responsibility is as the library for the 4000 Central Office personnel housed at 810 Vermont Avenue and its environs. Its function is similar to other government Agency or Department libraries which provide service to a specialized group management, administrative and policy-making personnel. In our Agency, the special interest is the veteran, including his medical care.

Its second area of responsibility is to provide backup in materials and information for the 165 hospital libraries in the system. Each VA hospital library necessarily must be limited in space, staff, funds, scope of collection; each must supplement what it has by using the resources of other libraries in their immediate area and what is available from other libraries in the VA system. The Central Office Library has the largest and broadest collection of materials from which these smaller libraries can borrow. In addition, it is ideally located in a city which is wealthy with specialized collections of information in every field. Our staff is quite familiar with what is available from other sources in Washington and is skilled in obtaining materials and services for our field libraries. We can locate this information and material, transmit it to the hospital libraries. We assure the lending libraries that VA has exhausted its own collection before going elsewhere. Thus we guard against becoming parasites in the library world.

We have one other responsibility, and that is to serve as a kind of "laboratory" for the Director of VA Library Service, Mr. Henry Gartland, in his job of determining policy for the entire system. Since we are an operational staff with similar interest and problems as those of our field librarins, the Director can and does seek our advice in procedures involving reference, technical processing and interlibrary loans. Essentially, this is the mission of Central Office Library.

Collection

As for our collection, we quote it to be 45,000 volumes about half of which are books and half journals. Approximately 90%

of our book collection is current material. Journal holdings vary from long runs of many titles to current-year-only for others. Subject coverage includes biomedical and paramedical titles, hospital administration, data management, employee development, VA management and administration. We have a comparatively strong medical collection and since National Library of Medicine moved to Bethesda, interlibrary loan demands from medical libraries in the downtown area increased many fold, particularly for journals. Over a period of 12 months, we loaned to 57 different libraries in the Washington area.

The reference service in our Library is particularly good, if we can rely on the favorable comments received from within and without VA. Our staff is small, but from the school that believes it provides a service and I underscore Service. In addition to routing reference, we specialize in locating a source (sometimes individuals) which has the requested information and place our patrons in direct contact with that source. We do this because our staff is too few in number to personally serve the percentage of 4000 employees in Central Office who need library service.

Some of the publications over the last 20 years of VA Central Office Library have become quite well known. The Basic

List of Books and Journals for VA Medical Libraries has undergone several revisions. It was originally compiled as a buying guide for our hospital libraries and today serves as a tool which can be used to bring their core collection up to date. Spinal Cord Injury started as Paraplegia in 1951. Requests for it come from all parts of U.S. and from abroad. We have just published a new edition of Bibliotherapy which is proving popular. These are a few samples of the types of bibliographies that our staff compiles.

Field Service

Now I want to tell you of some of the services which we provide for our hospital libraries. Since we have professional librarians running our hospital libraries, you may wonder what, why and how they need any support from Central Office Library. The principle reason is because we have resources which they do not, but which they often need. For example, we acquire many more books than any individual hospital library. Our new books are announced thru our monthly Acquisitions List. Becuase this List is also used as a selection tool by the librarians, we have arrangements with several publishers to receive copies of their books as they come off the press. We also provide xeroxed copies of journal articles for our libraries, with the limitation of one copy for research purposes. In order to make the maximum use of journals in the VA library network, a Union List of Periodical

Holdings in VA was computer produced in 1965. It has had 2 supplements and will periodically be brought up to date.

When certain reference tools at VA hospital library are non-existant or too limited to provide a literature search on a special subject, Central Office Library staff will make the search. This includes supplementing a MEDLARS search as well as compiling a non-medical bibliography.

I believe the hospital librarian is most impressed when our interlibrary loan liaison at CO pulls a rabbit out of a hat, so to speak, and identifies or obtains a very illusive item which she herself was not able to tract down; nor was it available thru the large national libraries nor the large academic libraries in her area. Her "thank you very much" makes our effort worth while. Becuase we have not only helped her; we have helped in the treatment of a veteran patient, and perhaps have in some way furthered the cause of medical research.

LIBRARY SERVICE IN A VA HOSPITAL

By

Miss Inez Callaway
Chief Librarian
VA Hospital
Washington, D.C.

Library Service in Veterans Administration Hospitals has as its ultimate aim to assist the Medical Staff in the medical care and rehabilitation of the hospitalized veteran. This service is a three-domensional one, having as its responsibility service: (1) to patients, (2) to the Medical staff, and (3) to other employees.

A brief review of the development of library service shows that service to patients is older than VA itself. The Veterans' Bureau established the first officially supported library service in 1923. Library service to be given by trained and experienced librarians would have as one of its most important duties the bringing of books to patients in the wards. When Veterans Administration was established in 1930 this service was continued. It was not until 1945, when a reorganization of the VA was made and a system of resident training for doctors in connection with medical schools was established, that medical library collections began to develop and increase.

Then for ten years library service had a two-fold responsibility (1) service to patients and (2) service to the medical staff. In 1955 when training programs began to develop for other types of employees the need became apparent for a third kind of literature for use of employees in connection with their official duties. Reading material in the areas of management, self-development and job improvement is now made available through the library on the basis of needs, interests, and available funds as these relate to the mission of the hospital.

With this background in mind, I will now discuss the library program of the Washington VA Hospital. Although there are basic similarities, no other VA hospital has exactly the same service.

This is a 710-bed General Medical and Surgical Hospital with a large number of research, education and training programs. This is a short term treatment hospital with an average hospital stay of 30 days, which treats all types of patients. As a general rule patients requiring treatment for longer than six months are transferred to another hospital. However, each case is considered individually and some may stay longer.

The library with its three areas of responsibility is under the supervision of the Chief Librarian. It is my responsibility, under the general supervision of the Chief of Staff, and with the aid of the manual provided by Central Office Staff outlining policies and procedures, to plan, organize, and implement a coordinated library service to meet the needs of this hospital and its programs. You have seen the location and the arrangement of our library. It is in a good location, easily accessible to all parts of the building. The arrangement is not so good, but at least the collections in adjacent rooms provide some supervisory control with a staff of only three librarians. One is delegated the responsibility of the Patients' Library and of Assistant Chief, the other the responsibility of the Medical Library. However, to assure the best service at all times, the staff works interchangeably in the two libraries and in administrative duties. This is essential with a small staff for continued smooth operation, especially during the absence of any staff member.

We have one Librarian Work-Study Trainee working 20 hours a week while attending Library School to obtain a degree in Library Science. The Work-Study program was established in the VA in 1959, and has been an aid in recruitment. Trainees are given experience in all phases of the library program.

Volunteers perform many worthwhile services in the library program, and the quality of service would be impaired without them. We have 8 volunteers at the present each working 4 hours or more a week. They are very reliable and regular in attendance. Of course, there is need for preplanning on the part of the library staff - the establishment of a list of jobs to be done in keeping with their abilities, and guides of instruction for performing the work. They help in such duties as taking the magazine cart on the wards, processing new books, circulation desk, alphabetizing and filing cards, typing, etc.

In cooperation with Industrial Arts Therapy, we have patients assigned to work in the library. They do most of the book shelving, keeping books in order, dusting, and according to their abilities perform duties similar to volunteers. This is a part of their rehabilitation.

In service to patients we do not attempt to build complete reference, research or classical collections. Instead we try to keep a well-balanced collection of up-to-date literature that meets the needs of the patients at this hospital. During our annual inventory we survey the collection for weeding. Since we recently moved into a new building with more than doubled bed capacity and we have a need for a larger collection, we are still in the process of increasing the size of the collection. Once this is built up to capacity of the available shelving, plans will be to discard about as many titles as we add each year.

Book procurement is accomplished through our Supply Division. We are able to get books for the Patients' Library through a local source that is very satisfactory. Medical books are ordered through the General Services Administration contract.

Centralized cataloging is done by Central Office for all VA hospitals. Dewey Decimal Classification and Library of Congress subject headings are used for the Patients' Library. Latest edition of NLM Classification and subject headings are used for the Medical Library. We request cataloging service when books are ordered. Complete sets of catalog cards, shelf list cards, pocket and book cards are sent.

Direct service to patients is of prime importance in our program (I am not going to use the word "Bibliotherapy" because I am not sure the service we give fits your definition of the word.) About one third of our patients are psychiatric. The psychiatric wards are all open and patients are free to go to other parts of the building. Instead of coming to the library in supervised groups as in some hospitals, they can come and go as they choose. Therefore no group activities are planned for them in the library. All ambulatory patients are encouraged to come to the library to browse, to select books and to read. Copies of current magazines are available for reading in the library. A section for new books is so designated. Ample space is available for wheel chair patients to browse.

Taking books on the wards to nonambulatory patients is a very important service. This service is done by the librarians only, for the following reasons:

(1) Has a better knowledge of the book collection and can better select books suitable for the patients she will visit.

(2) Is better acquainted with the patients and has more opportunity to familiarize herself with their educational backgrounds, vocational experiences, interests, and reading needs.

(3) Contact with patients affords an opportunity to know what fields of interest are most in demand, thus aiding in the wise expenditure of books funds.

(4) By training and experience, will be better able to give reading guidance or create an interest in reading.

An aim in library work is getting the right book to the right reader. This is important in dealing with the patient.

To many of us, reading is a enjoyable pastime wherever we happen to be. Reading in bed - perhaps just a few minutes before we go to sleep at night - is a delightful pastime for some. Reading in bed when one is ill may be a vital necessity which can help adjust to the confinement. People who are ill are often discouraged and anxious, and do not cooperate with their treatment because they are not in the right frame of mind. They need physical relaxation and mental stimulation, and these can often be found in books better than in any other form of entertainment. We spend as much time as we can with individual patients, discussing his reaction to what he has read to serve a 2-fold purpose. It increases his self-esteem to find someone who asks his opinion, and it gives us a chance to evaluate the reading interests and capacities of the patient and provides a criteria to use in suggesting reading material. What is depressing for one may be stimulating to another, and every effort is made to recognize the differences of patients in their response to reading, just as there are differences in their response to drugs or other forms of treatment. All this presents a challenge to the librarian. While many patients will have specific books in mind that they want to read, others will need to browse and may request help and suggestions for "a good book." The information gained in our contacts with patients is used as a help in making up the cart forthe next trip and as a guide in book selection.

We read reviews with the question, "Would it be of interest to patients?"

This service by the librarian is supplemented by another weekly visit with a magazine cart by a volunteer. We have multiple subscriptions to a number of popular magazines, (as our budget will permit). One copy is displayed in the library for ambulant patients to read there, others are taken to the nonambulant patients on the ward. The magazines provided by subscriptions are supplemented by undeliverable magazines obtained from the Post Office.

A member of the library staff attends the Integrated Patient Care Rounds. This group consists of members from the services that give direct care to patients, meeting on designated wards each morning to discuss the diagnosis, treatment, prognosis and planning for discharge of patients. The discussion is led by the ward doctor. In this way we often learn of patients with special problems that we may be able to help. It may be a blind patient, or one with other physical handicaps (such as mulitple sclerosis, cerebral palsy, muscular dystrophy, arthritis, infantile paralysis) that makes reading difficult or impossible without aids. You have seen the display of such aids in the Library. We may learn that a patient will be hospitalized for a longer than average stay, then we can make a special effort to help him, by getting special books from a public library, or just by spending a little more time with him if he wants to talk. These rounds encourage closer integration and understanding among all services in the care of patients. We solicit and appreciate the cooperation of other services (Nursing Service, Social Work Service, Psychology, Physical Medicine and Rehabilitation) who let us know of patients that might benefit by some special service.

The heaviest work load of our service is in the Medical Library. There is a complexity of hospital programs and of the Research, Education and Training programs. It is not the intention to build up a large research collection of literature. Limitations on space and the budget prohibit this. We do attempt to provide a well balanced basic collection of monographs and texts and a file of at least ten years in periodicals of about 140 titles. Central Office provides a frequently revised basic collection list as a guide in checking the collection.

We must depend on interlibrary loan service to supplement our collection. Much of the time of the staff is spent in verifying requests and in locating, requesting, obtaining, keeping records, and returning interlibrary loans. By checking the VA Union List of Serials first, we borrow all material available from Central Office and nearby VA hospitals. In addition we have established loan service with about 25 other libraries in the area. We have lists of holdings from a number of these and try to distribute our requests so as not to be an excessive burden to anyone.

In addition to patient care in six specialty areas (medical, surgical, psychiatric, neurology, tuberculosis and PM&R) there is a large Outpatient Clinic, and a Mental Hygiene Clinic where psychiatric patients have day care treatment and return to their homes at night. They are specially staffed and equipped to give specialized treatment in such categories as cardiac surgery, corneal transplant, oral surgery, neurosurgery, plastic and maxillo surgery, radiation including cobalt, radioisotopes, renal dialysis and thoracic surgery.

There are about 40 Research Units doing highly specialized research. Publications by staff members indicates some of the activity.

The Chief Librarian is responsible for verifying the listing in the Annual Report of Medical Research papers which have been written by staff members and have been published in scientific and professional journals, to insure accuracy and uniform entries. We have used the MEDLARS of National Library of Medicine extensively. We participated in the special evaluation of MEDLARS during the past fiscal year. Librarians were responsible for assisting staff in the format of requests, for sending in requests, receipt of bibliographies, then obtaining appraisals and returning.

There are Resident Training programs in 18 different specialties with about 80 residents. On July 1, 1967 an Intern Training program was started with 13 interns. We have medical students, 150 to 200 at a time, from three medical schools, rotating through several services. We have training programs in about twelve areas such as: Assistant Hospital Directors, Chief of Staff, Management Analysts, Hospital Administrative Residents, Social Workers, Occupational Therapy Students, Dental Interns, Nursing Students, Audiology and Speech Pathology, Medical Records, Psychology and Librarians. With this number of varied programs, new people are coming continuously, so it is a real problem to try to give orientation in the use of our library, to keep adequate records of staff, services available, and how to use indexes, references, etc. and how to locate material.

We have a very active Medical Library Advisory Committee to assist the Librarian in policy making, in selection of new acquisitions, in the decision on which journals should be bound and retained, etc. The Committee meets at least once a quarter. The Library is open 8:00 to 4:30 five days a week. However, a key is available for the staff to use the Medical Library at all times.

In our service to other employees we have a small collection, located in the Patients' Library, in the fields of supervision, administration, automation, job development, and self improvement. It serves as supplemental references for the training programs, for those taking courses, and for those interested in job development, and self improvement. The collection is supplemented with interlibrary loans when necessary. Employees are permitted to use the Patients' Library if such use does not interfere with service to patients. We use various mediums for publicizing the library service - bulletin boards, displays, special bulletins, personnel bulletins, daily activity bulletin, etc.

Circulation statistics cannot fully measure the quality of hospital library program nor the extent to which the Library is accomplishing its objectives. No actual count is made of such of the material used - no charges or records are kept of magazines and paper back books. However, we do let the administration and Central Office know something about our program through a Quarterly Statistical Report, and the Annual Narrative Report in addition to a semiannual Systematic Review and Appraisal and the Annual Station Evaluation Program.

MEDICAL LIBRARY ASSOCIATION PROGRAMS

By

Mrs. Helen Brown Schmidt
Executive Secretary
Medical Library Association
Chicago, Illinois

Mrs. Schmidt spoke from notes only and a copy of her talk was not available. In essence, she described the current programs of the Medical Library Association which include: an Exchange Service, by which the 700 institutional members receive 100 - 150 page lists each month, enumerating duplicate journals that are available to these members for the cost of transportation; a Placement Service, listing without charge, to members and nonmembers alike, positions that are available in health sciences libraries and people who want to change jobs; an Answering Service for questions about library problems by carefully screened specialists; the Continuing Education program of workshops, one-day courses, and next year, a week-long institute. MLA also evaluates courses in medical library work that are offered in ALA accredited library schools to determine whether Association-wide standards are met; encourages the writing and publishing of books and periodicals needed by the profession; offers a certification scheme to foster and recognize formal professional training; has an annual lectureship on some phase of medical library history or philosophy; and administers a recruitment program of scholarships. It publishes a concise but comprehensive career leaflet, a list of ALA accredited library schools and MLA approved courses in medical librarianship, and maintains on file the names of medical librarians all over the country who are willing to discuss a career in the medical library field with prospective recruits.

COMMENTS ON THE REGIONAL MEDICAL PROGRAMS

By

Mr. Alphonse Strachocki
Hospital Administration Consultant
Regional Medical Program
National Institutes of Health
Bethesda, Maryland

It is a pleasure for me to be able to take part in your meeting and to have the opportunity to discuss the Regional Medical Program, which is commonly referred to as the "Heart, Cancer and Stroke Program." In preparing for this presentation, I tried to anticipate what I thought would be of interest to me if I were a hospital medical librarian. It appeared to me that I would be interested in 2 basic questions: First, what is the Regional Medical Program all about and, second, what does it have to offer hospital libraries? The answer to the first question can be discussed rather easily because it can be related to its legislation and development. The answer to the second question is somewhat more difficult because it depends to a very large extent on your "input" as medical librarians.

In discussing what the Regional Medical Program is all about, it might be helpful to summarize some of the events leading up to the legislation authorizing the program. The program had its beginning with the appointment, in May 1964, of the President's Commission on Heart Disease, Cancer and Stroke. The President instructed the Commission to recommend steps which would reduce the incidence of these diseases through new knowledge and more complete utilization of the medical knowledge already available.

Throughout 1964, the Commission, under the Chairmanship of Dr. Michael DeBakey, heard the testimony of hundreds of witnesses; sifted volumes of information and in December of 1964 issued "Report to the President; a National Program to Conquer Heart Disease, Cancer and Stroke." It contained 35 recommendations emphasizing two main themes. First, people everywhere should have the benefits of medical scientific advances and, second, a fusion of science, education and service is needed to reach this goal.

In his health message to Congress in January 1965, the President urged implementation of the Commission's recommendations. Congress quickly responded with a bill introduced into both Houses.

During the committee hearings, many questions were raised about the proposed bills. Some felt that what was being proposed was a vast Federal complex of research and treatment facilities that would be superimposed on the nation's existing medical capabilities. Others were sure these facilities and their programs would eventually overshadow and even replace them. Further discussions clarified many of the issues which in most instances were really problems in semantics. A series of changes in the proposed legislation followed and the final act was signed into law by the President on October 6, 1965.

During the legislative process, Congress strongly indicated that the program should be dependent upon local initiative and decision-making. It substituted the words "regional programs" for "regional centers" and, in so doing, emphasized the fact that this was a program which sought to develop true cooperative arrangements rather than a monolithic system for the logistics of the delivery of health services.

I will not attempt to review in depth the details of the final act passed. However, the essense of the program is contained within the following few well-chosen words included in the purposes of the Act.

(a) Through grants, to encourage and assist in the establishment of regional cooperative arrangements among medical schools, research institutions and hospitals for research and training and for related demonstrations of patient care in the fields of heart disease, cancer, stroke and related diseases.

(b) To afford to the medical profession and the medical institutions of the Nation, through such cooperative arrangements, the opportunity of making available to their patients the latest advances in the diagnosis and treatment of these diseases and

(c) by these means to improve generally the health, manpower and facilities available to the Nation.

What is the functional arrangement by which these purposes are to be achieved? There is no prescribed pattern for regional medical programs to follow. If there were, it would negate the whole concept of regional planning. Rather, the legislation provides a flexible framework for the planning and implementation of varying approaches appropriate to the specific region. Such flexibility is compatible with the voluntary nature of medical and health care practices and institutions in this country.

By definition, a regional medical program is a cooperative arrangement among a group of public or private non-profit institutions or agencies engaged in research, training, diagnosis and treatment relating to heart disease, cancer, and stroke. The group of institutions or agencies must:

1. Be situated within a geographic area deemed appropriate. It may be composed of part or parts of one or more states; it may be a city, a metropolitan area, a portion of a state, and an entire state or parts of several states. The actual boundaries of the region are determined by the region, often after discussion with adjoining regions. Important factors in this determination are population trends and patterns, institutional relationships and the presence and distribution of educational and health facilities and programs.

2. Consist of one or more medical centers, one or more clinical research centers and one or more affiliated hospitals.

3. Have in effect adequate cooperative arrangements. Thus, cooperation and dialogue between the medical center and the community are a necessity.

Briefly then, the purpose of each regional medical program is to make available, through a coordinated and cooperative effort, the latest advances in the diagnosis and treatment of heart disease, cancer, stroke and related diseases.

Within this concept of Regional Medical Programs, the need for continuing education takes on significant meaning. It becomes a regional medical program's responsibility to explore all feasible means for the continuing transmission of new knowledge from the research centers to the health profession for application to patients with heart disease, cancer and stroke. Medical literature has long been the most important mechanism for the communication of new knowledge, reaching far more people than is ever possible through person-to-person contact.

Continuing education forms a vital link in the "research-to-practice sequence," since it is recognized as one of the primary vehicles or systems of information-transport available to us. It becomes quite apparent that the community hospital library is part of this linkage. The community hospitals in effect are the medical teaching centers for their communities and hospital libraries are an essential key for bridging the "knowledge-to-action" gap.

In as much as the Regional Medical Programs provide for a coordinated approach in the implementation of health programs, I would urge each one of you to become familiar with the planning for the Regional Medical Program in your area. You can provide critical "input" regarding the needs as they relate to hospital libraries. Without the involvement of medical librarians, there is no assuring that there will be any significant development of medical library programs.

You all are more familiar with the needs of your discipline than I am, but to start you thinking, I would like to briefly describe a couple of projects under way as examples of what is going on in the area of medical libraries.

The Kansas Regional Medical Program has a project underway to link regional library resources. The aim of this program is to improve the links between regional libraries and to make them function as a single library. The program essentially has two facets. One is to examine the existing situation by evaluating holdings and utilization of library resources; studying new approaches to utilization of library resources; studying time involved in the delivery of "hand copy"; and evaluating the importance of time lag in frequency of use. The other facet is to update the library resources by providing MEDLARS bibliographic search capacity. It will be necessary, therefore, to train searchers and to utilize computer resources.

In the Washington-Alaska Region there is a project to establish a community medical library at Anchorage. Alaska has never had an adequate medical library and since Anchorage is the largest center in Alaska, it appears to be the most logical location for the whole state. The Alaska Native Medical Center, which is a Federal government facility, has made space available and has recently hired a librarian. One hundred monographs and 50 medical journals will form the basis of the collection. The immediate objective is to build and catalogue the collection. Beyond this, it is hoped that the library will disseminate current information; provide reference service; compile bibliographies; provide supervisory service for small libraries elsewhere in Alaska; develop a union catalogue of medical holdings at all medical establishments served; and provide interlibrary loan service.

The Utah Region has a project to develop an information library and telephone consultation service. Utah has a particular problem in providing its physicians quickly with information on new approaches to the diagnosis and treatment of stroke. It has low urbanization, lack of readily available medical library facilities, and very few neurological consultants. Therefore, it has designed this two-pronged program, both aspects to be under the direction of the Stroke Project Director. Under the library part of the program, the Director will classify and catalogue pertinent articles and will regularly screen about 30 periodicals and the Index Medicus. Upon request, specific articles will be mailed or phoned when necessary. Under the telephone consultation part of the program, the Director will maintain a 24-hour telephone consulting staff who will give further advice by mail if necessary.

In Wisconsin, there is a project to develop a telephone dial access tape recording library for physicians. This program is designed to provide immediately, accessible, authoritative, core information in heart, cancer and stroke in the following categories: emergencies, recommended procedures for specific diseases and conditions and newer developments. The library will have approximately 100 tapes on self winding cartridges. These tapes will be of 4-6 minutes duration and will be available on a 24-hour basis. Listings of available tapes will be circulated among the physicians of the region. The physicians may call toll-free at any time and request a tape to be played over the phone.

These are only a few examples and I'm sure that each of you have many more suggestions. As a start toward the implementation of these ideas, I would suggest that you contact your Regional Coordinator regarding the opportunities for the inclusion of your professional specialty in your regional program. May I suggest the following steps as one possible approach.

First: As a Group or Committee effort, identify the pertinent medical library activities already in progress regarding

your own discipline Give the efforts greater visibility as well as moral support through total participation. In as much as Regional Medical Program funds are designed to augment existing resources, they can aid in the expansion and in the establishment of new medical library programs.

Second: Identify the members of the Regional Advisory Group and/or the Coordinator and ask to review with them the boundaries of the region, the planning and operational proposals to determine the extent to which your profession's needs are considered.

Third: Having determined the needs and having identified the level to which the region's proposals address themselves to meeting these needs, draw up a plan of action which, to the best available knowledge, will contribute to the satisfaction of the unmet needs. Present a suggested format to the coordinator for inclusion in the original or in supplemental Regional Medical Program proposals. His procedure will be to present your Group's proposal to the local Regional advisory group for their consideration and action. The suggestions thus presented to the regional coordinator should be carefully structured and sufficiently explicit so as to stimulate professional dialogue. Suggested course or courses

of action should contain evidence of need; a statement of current activities; clear-cut objectives; viable evaluation format; and some indication of how these efforts will add to existing cooperative arrangements and contribute to the goals of the regional efforts to improve patient care in heart disease, cancer and stroke.

I hope that I have given you some food for thought with this brief overview of the Regional Medical Program. But even more, I appreciate this opportunity to suggest a course of action which I trust will aid you in satisfying your profession's needs through your Regional Medical Programs.

WASHINGTON, D.C. REGIONAL GROUP MEETING 1967

MEDICAL LIBRARY IN THE REGIONAL MEDICAL PROGRAM

By

Mrs. Jacqueline Felter
Director, Union Catalog
Medical Library Center
New York, New York and
President-Elect, MLA

A recent issue of the New Yorker (September 16, 1967, p. 42-46) reported one of the rare interviews granted by my favorite politician, Mr. Daley Unruh. This seasoned "technician of politics" remarked that the candidate for office should beware of leading questions about policy lest he go "way out on a limb with some foolish proposal.... Specific programs," he added, "are out of date in a month." On the other hand, Unruh advised the candidate, "you should indicate some of the things you are going to do. Not in order to come up with a detailed or comprehensive program - but just enough to give people some confidence that you really understand the problems and have some ideas." This is timely advice for one who is making her first appearance on behalf of MLA.

I do not propose to present a "position" paper of the Medical Library Association vis-a-vis the regional medical program. MLA's position has always been clear: It has fostered the continuing education of physicians and other health services personnel through libraries. I propose to review what MLA has been doing and to dream a bit about what more it can do in the future, and though I have discussed this topic with Scott Adams, mainly my observations are unofficial, influenced by proximity to the regional movement in my own community.

Another of my favorite persons is one of the leading characters in a play of some years ago called Jacobowski and the Colonel. Jacobowski was a delightful gentleman whose duty it was to extricate the Colonel from all sorts of difficulties. He was never at a loss. There were always "two possibilities." So, with respect to the relationship between the Medical Library Association and the regional medical program, I think there are two possibilities - or perhaps, one probability and one possibility. Probably the regional medical program will exacerbate some of the problems MLA has faced for a long time. These fall into two familiar categories: Manpower and standards for libraries. Possibly the regional medical program will create a climate favorable to the solution of these problems. The figurative climate, like the weather, varies throughout the geographical areas of the country. Since the RMP will direct its efforts toward strengthening the grass roots health services, most of the time today I shall address my remarks to the grass roots library situation. In other words if the RMP is going to make the outlying voluntary hospital assume responsibility for the continuing education of local physicians, the hospitals will have to acquire teaching materials. The library is one of a number of teaching materials which, presumably, should be acquired where they do not exist and strengthened where they are weak.

Let's take manpower first. In spite of the fact that MLA membership has grown from 223 professional (individual) members in 1946, when the Association resumed national meetings after World War II, to 1,478 individuals when the 1967 annual meeting took place, recruitment is and must be a never-ending activity. It might be considered encouraging that, according to Frarey's "Placement Picture - 1966" (Library Journal 92:2131-2136, June 1, 1967) medicine, including nursing schools, and hospitals, including the VA, attracted 27 percent of the library school graduates, second only to science, technology, and industry, which took 36.73 percent. Yet the Heart, Cancer and Stroke program pointed out in essence the fact that, in 1963, if the professional librarians were alloted to the existing medical libraries on a per capita basis, there would be less than one-half a librarian per library. (The actual figures are "3,000 professional librarians serving 6,389 medical libraries.") The catch is, the number of librarians accepting special library positions is only 10 percent of the total number of graduates for the year of the report, 1966. Obviously distribution of manpower also is one of the problems. Naturally there are clusters of librarians in urban areas and medical centers, while, in the hinterland, they are scattered sparsely. Therefore we shall not only have to recruit librarians even more vigorously than heretofore, but we shall have to recruit manpower for the locations where it is needed. Furthermore, we shall have to recruit personnel for different levels of performance, because there can not be only chiefs or only indians - we need both. And that leads us to the subject of education and training.

Before I leave the subject of recruitment, however, I'd like to suggest that a change of climate would benefit recruitment efforts. Librarians have been, for the most part, the only recruiting teams for their own ranks. If guidance counselors stress librarianship, it is because librarians urge them to do so. If hospitals include the library in the career day programs, it is because the librarian insists. Last week I sent for a booklet I heard about during a Blue Cross radio commercial. It is entitled The Hospital People and is a special issue of Blue Print for Health, a serial publication of the Blue Cross Association. Case histories illustrate the functions of the hospital and the activities of specially trained personnel. You know what? There wasn't anything about the medical librarian. The omission was especially appalling because the Blue Cross Association is located in the American Hospital Association's building in Chicago where Blue Cross personnel must rub shoulders with the librarians every day. Publicity costs money and MLA's budget is modest. We do distribute our own recruitment brochure. But utilizing the publications of other health service organizations to toot our horn would be an astute and economical means of recruitment. So in one of my dreams I would like to see the MLA recruitment committee and representatives of the regional groups get to these organizations and enlist their help. I repeat - this would be a worthy project on the local level for regional groups.

Now let us consider education and training. The Heart, Cancer and Stroke Program mentions "the need to attract those (persons) of unusual ability and creativity who can provide leadership in the future to a field which must develop a milieu of academic scholarship relating to its disciplined professionalism ....." Describing the librarian's qualifications, the program states further: "Whether he is called librarian or communications specialist or by any other designation, his department must

develop a research and teaching capability as well as provide comprehensive service to biomedical clientele." and "be able to assume leadership in the administration of a functioning organization which will undoubtedly develop the dimensions and the status of a department of the medical school." These are worthy objectives. At present, of course, there are two gaps between reality and vision. On the one hand, as we already know, there aren't enough of these exceptional librarians to go around, even though the internships and fellowships financed by grants from the National Library of Medicine are making such people more numerous. On the other hand, the grass roots hospitals won't be ready for people of this caliber until the regional medical programs are in full operation. Maybe some hospitals never will need such people. Those are the reasons why I believe that as a solution to the problem of supply and demand we need several levels of intellectual and practical performance with appropriate job descriptions and educational qualifications for each. And I believe we must deploy our personnel judiciously - ration them, if you will - some to mind the store and others to serve as teachers and consultants. Regionalization should create a climate in which such collaboration - regional personnel networks - will be possible.

There is a call these days for excellence in librarianship, but it seems to me that the excellence about which there are so many speeches and articles is an attribute only of top administration. Excellence, in my opinion, should and can be obtained on all levels. To make this possible, however, the practitioner on each performance level should know exactly what he is to do; and should be equipped with the appropriate knowledge or skills. There are individual differences in people too. Everyone is not tempermentally suited to research or teaching or administration; some people are better at practice than theory. To perform with excellence is to do a suitable job in the best possible way. From director to clerk, that is true job satisfaction.

You are thinking, no doubt, that MLA already takes cognizance of different levels of performance in its certification program. Our certification grades, however, recognize different degrees of preparation. Better job descriptions - sometimes called standards - are needed, I think, so that our certified librarians can find the nitches they fit in best. Well-defined job descriptions do not imply a rigid hierarchy. Moving upward from job to job and responsibility to responsibility should be easier if one knows what the job is and what preparation for it he should have. Furthermore, libraries, like people, have individual variations, but the similarities are usually greater than the variations, so job descriptions are at least guidelines. Incidentally it should be noted that the MLA certification program is not static. Changes in the qualifications of the grades have been made in the past and on Ad Hoc MLA committee is to be appointed to set up a new certification code consistent with changing needs.

I come now to the subject - for some people, the touchy subject - of library technicians. Mildred Langner, in her President's Page in the Bulletin of the Medical Library Association, 55:93-94, January 1967, has stated the case admirably for medical library technicians. Antagonism toward technicians was vehemently expressed by Samuel Sass in an article in Library Journal 92:2122-2126, June 1, 1967. I can not agree with Mr. Sass that, because the technician curricula, such as those in the community colleges, are ill-conceived and the students taught badly and poorly prepared, the whole program should be scrapped. In his alarm at the possibility that library technicians will call themselves librarians, enjoy delusions of grandure, and demean librarianship, I detect a feeling of insecurity in the profession. If the curricula and teaching are unsatisfactory, I fear that it is because the librarians have been laggard, have failed to take command soon enough. If librarians make haste to take command as curriculum advisors and teachers, it seems to me that both conditions will be corrected: there will be suitably trained technicians and more self-confident librarians. In its own field MLA is taking command though perhaps somewhat belatedly, too. Our President has appointed the Committee on Standards for Medical Library Technician Training, of which Helen Yast* is chairman, to (1) define technician job specifications and (2) recommend training course curricula,

Before I leave the subject of training there are a couple of other comments to be made. The Heart, Cancer and Stroke program states that "programming must begin with an energetic effort to encourage more institutions to establish programs in medical librarianship with adequate funds to initiate such programs and attract appropriate trainees." The Medical Library Association can look with pride at its record of aggressive action and progress in this direction; there are 13 approved courses in medical librarianship. I think we can be assured that MLA's efforts will not stop here.

---

*Helen Yast is the architect and director of the library institutes sponsored by the American Hospital Association every eighteen months in various parts of the United States.

The other comment pertains to continuing education. you are, of course, familiar with MLA's impressive array of Continuing Education courses. They encompass basic library practice such as reference work and interlibrary loans and new procedures such as machine methods. These also can't stop here; librarians contributing effort to the continuing education of physicians can not neglect their own. I have a suggestion for another course. Audiovisual Aids and other communications media will play a prominent role in the dissemination of information envisioned in RMP. Librarians must accept these media and correlate them with their old favorites, the book and journal. I propose, therefore, that there be added to our Continuing Education armamentarium a course in communications media.

Finally, let us touch on the matter of standards for libraries. Judging by the number of references to it, many of us still wince at the recollection of an exchange of opinions between the then director of the Joint Commission on Accreditation of Hospitals and a panel of librarians a few years ago at an annual meeting of M.L.A. When taken to task because the Joint Commission does not spell out criteria for libraries in its requirements for accreditation, the director replied that, if librarians want better hospital libraries, it is their responsibility to make them. The librarians took the stand that generally, because of the absence of standards and lack of enthusiasm of hospital administrators, they were working in an incompatible, if not hostile, environment. I hope that RMP will change the climate affecting the development of library resources also.

I believe, however, that we cannot depend upon this development coming about without continued effort on our part. Librarians must play an active role. In some regions they may already have fallen behind, but most regions are in the planning stage, so we have a chance to catch up if we act immediately. The librarians in Connecticut were forsighted; they have already been allotted a budget line in the planning grant and their Task Force 7: State-Wide Medical Library System is already at work beginning with a survey of existing hospital library service. On the other hand, I must confess to sins of ommission in the Greater New York Area; we did not get a library line in the planning budget. I have been told, however, that funds can be diverted for our purpose. But more significant, I think, was the reaction of Dr. Larkin, our RMP Director, when I spoke to him of the omission. His excuse was, there had been "so many details" to work out. Omission of library planning from the RMP grant application implies to me that library service is still a small mole hill on the surface of the medical world. We can't let this continue; we must get to our RMP planning forces at once. Promotion of library service in RMP - as one of the whole communications media - is a project that may well be done by the librarians in the local and regional groups.

A brochure prepared by a committee of MLA has worked effectively toward promoting hospital libraries with individual administrators. In promotion, however, numbers of people are more effective than individuals (witness pressure groups). And when the approach is to groups of people, the effort is more economical, as when one goes fishing with a net instead of a rod and line. In retrospect I fear we have failed to see the advantage of the group-to-group approach. Now, what groups might we work with? I have picked the brains of a number of my colleagues and luncheon companions, and the following are some of their suggestions.

Here and there one finds responsive individual administrators. Last week at the joint meeting of the Philadelphia and New York Regional Groups I met a hospital librarian who was attending her first meeting. She was diffident because she had recently moved from the public to the medical library. She came, in spite of her shyness, she said, because her administrator urged her to. That's the kind of administrators we want. But how can we get to masses of them: How can we inject medical library promotion into their curricula? Have we ever approached the schools individually? Or gotten through to them via the Association of University Programs in Hospital Administration? As far as I know we haven't used this approach. I think we have missed the boat - but let's catch up with it now.

Let's make another effort to get the cooperation of the Joint Commission on Accreditation. Our ammunition gets better every year. Could the Joint Commission be persuaded to use the recurring "Basic List of Books and Journals for Veterans Administration Medical Libraries," now in 1967 edition, (352 books and 109 journal titles) or Al Brandon's "Selected List of Books and Journals for the Small Medical Library" (388 book titles, 140 journal titles) and Edith Blair's "Basic Reference Aids for Small Medical Libraries" (173 titles) as checklists for the evaluation of the hospital medical library? (Both in Bulletin of Medical Library Association 55: 141-159 and 160-175, April 1967.) These are quite modest criteria for hospital library resources; they represent a good basic small library collection. If the Joint Commission should adopt them, however, MLA must assume the obligation to keep them up to date. Henry Gartland, Director of VA Library Service, has taken this responsibility for his List and he will testify that it is no easy job. We have so many capable people, though, surely we could assume this responsibility. It would be worth the doing.

Similarly, there is another boat we might catch belatedly. The residency review committees of the specialty boards usually ask for a list of journals pertinent to the specialty that are received currently by the hospital library. The librarian has either to make a new list for each review or update a previous list, if she was foresighted enough to keep it from review to review. I don't know why we never thought of offering as a service ready-made lists of specialty journals that the residency review committees could use as checklists. If we can demonstrate that MLA can render services to the accreditation agencies, perhaps we can enlist them as sustaining members. I'd like to refer this project to our Advisory Committee on Medical Library Problems. Librarians among whose clientele there may be specialists who are members of their residency review committees can also be missionaries and interventionists.

To return to the regional scene, I have not dwelt on the Regional Medical Library Program of the National Library of Medicine, funded under the provision of the Medical Library Assistance Act, because you are already familiar with it. The individual regional library systems of the great national biomedical communications network that this program envisions will be a tremendous boon to the grass roots libraries with its free interlibrary loan and/or photocopy and MEDLARS services. Of course, these library systems will be prototypes for those developed separately within the framework of RMP, and where both regional programs exist they should work in compatibility. There are, however, fifty RMP enterprises in the planning, if not yet operating, stage, whereas the regional library systems, according to the present forecast, will be a lesser number.

This is the reason why I reiterate my previous statement. Librarians must be the aggressors in order to get regional library planning into RMP planning. RMP will depend for information on regional surveys of hospitals and continuing education of physicians on which to base their operations. We must see to it that library data is obtained in these surveys and fed back to us. There should be at least one library consultant in each RMP. Through the RMP we must persuade hospitals to incorporate library collections in communications centers, building new collections or building on existing collections. I could exhaust you with suggestions, but I'd rather not do so now. I need to conserve your energy, because we must act tirelessly on behalf of libraries in RMP.

WASHINGTON, D.C. REGIONAL GROUP MEETING 1967

Mrs. Tedesco asked me to talk about the role of MLA in regional medical planning. I have spent my time telling what you, I, we can do, because you, I, we are the Medical Library Association.

Distribution: CO: N
SS (11A3) FLD: HA, DO, OC, OCRO - 1 ea.